VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

January 2, 2015

Mr. Francis Cheney, III, Administrator
Maple Lane Retirement Home
33 Maple Lane
Barton, VT 05822-9494

Dear Mr. Cheney,

Enclosed is a copy of your acceptable plans of correction for the survey conducted on November 12, 2014 . Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0140	A. BUILDING: _____ B. WING _____	11/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE RETIREMENT HOME	33 MAPLE LANE BARTON, VT 05822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site re-licensing survey was conducted by the Division of Licensing and Protection on 11/12/14. The following regulatory violations were identified.	R100	please see AH. for details	
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interview the facility failed to complete an initial Resident Assessment within the 14 day required time frame, for 2 residents. (Residents #3 and #5). Findings include: Per record review the initial Resident Assessment had not been conducted as of the date of survey for Resident #3, who was admitted on 10/8/14 and Resident #5, admitted on 9/4/14. The RN Nurse Manager confirmed, during interview on the afternoon of 11/12/14, that the assessments had not been completed in a timely manner.	R134		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES	R145		

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R145	Continued From page 1 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the home failed to assure that the care plans reflected the current needs, care and services for 1 of 5 residents reviewed. (Resident #3). Findings include: 1. Per record review the care plan for Resident #3 did not reflect the resident's history of and risk for wandering and aggressive behaviors towards other residents. Progress notes, from admission through 10/15/14, reflected the resident's ongoing confusion and wandering in and out of other resident rooms, taking and wearing clothing that belonged to other residents, as well as occasionally wandering outside the home. On 10/10/14 the resident was attempting to light a cigarette by placing it inside a toaster in the kitchen. Resident #6 attempted to remove the toaster in an effort to prevent injury and Resident #3 became angry and aggressive, shoved and hit Resident #6, threw a dish at and hit a staff member and threatened the staff member with his/her cane. A subsequent note, on 10/11/14, indicated Resident #3 attempted to hit another resident during a heated verbal altercation. Despite the documentation in progress notes that staff had conducted 15 minute checks for a period of time and placed an alarm at the door to reduce the risk of wandering outside, Resident	R145		

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R145	Continued From page 2 #3's care plan did not address the wandering risk and did not reflect goals and interventions related to the resident's confusion and potential for aggressive behaviors. The Nurse Manager confirmed that Resident #3's care plan did not address the risk for wandering or the potential for aggressive behaviors.	R145		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced	R179		

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R179	Continued From page 3 by: Based on record review and staff interview the home failed to assure that the required 12 hours of annual training were completed by 4 of the 5 direct care staff reviewed. Findings include: Per interview, conducted at the time of review of staff training records, the nurse manager confirmed that 4 of the 5 direct care staff reviewed had not completed the full 12 required hours of in-service training, during the previous year.	R179		
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced	R181		

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R181	Continued From page 4 by: Based on record review and staff interview the home currently employs a staff member with criminal convictions and failed to obtain a variance from the Division of Licensing and Protection, for 1 of 5 staff reviewed. Findings include: Per review, 1 of 5 currently employed direct care staff had a positive finding for criminal convictions in 1985, 2006 and 2008, identified during background checks at the time of hire in September of 2014. The facility Administrator confirmed, during interview at the time review, that a variance had not been requested as s/he had not been aware of the need to request a variance for staff employed in Level III homes.	R181		
R189 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interview the facility failed to have the initial Resident Assessments in the records of 2	R189		

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R189	Continued From page 5 residents. (Residents #3 and #5). Findings include: Per record review the medical records for Residents #3, admitted to the home on 10/8/14, and #5, admitted on 9/4/14, did not contain the initial Resident Assessments. The RN Nurse Manager confirmed, during interview on the afternoon of 11/12/14, that the assessments were not in either Resident's record.	R189		
R248 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.c. All work surfaces are cleaned and sanitized after each use. Equipment and utensils are cleaned and sanitized after each use and stored properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the home failed to assure that all work surfaces and equipment were maintained in a clean and sanitary manner. Findings include: During initial tour of the facility kitchen, at 9:00 AM on 11/12/14, the following observations were made: 1. The grates of the hood vent, located directly over the stove in the home's kitchen, were heavily soiled with grease and dust. 2. The corner of a piece of metal sheeting, which provided a cover for insulation and was located on the ceiling directly above a food prep area,	R248		

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R248	Continued From page 6 had become loosened and detached and had insulation debris and dust hanging from it. 3. The interior walls and shelving of both the stand up freezer and refrigerator, used for storing food and drinks consumed by residents, were soiled with dried on liquid stains and food debris. 4. The interior walls of a refrigerated cooler, used to store food and drinks consumed by residents, and located in a back room where laundry equipment was stored, were covered with thick ice and frost. The above observations were confirmed by the Nurse Manager who was present at the time of tour.	R248		
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the home failed to maintain a safe, sanitary, homelike and comfortable environment. Findings include: Per observation, during initial tour of the home at 9:00 AM on 11/12/14, the following observations were made: 1. The two bathrooms utilized by residents and located in the halls next to resident rooms #3 and	R266		

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R266	Continued From page 7 #7, each had large water stains on the ceiling tiles. In addition, the ceiling directly above the sink in the bathroom next to room #7 was bulging and had small cracks. 2. There was a cracked window pane in the window located above the kitchen stove along the interior wall between the kitchen and a common area of the home near the nurse's station and dining room. These observations were confirmed by the Nurse Manager who was present at the time of tour. 3. There was a very strong odor of urine that permeated the second floor of the facility. The Nurse Manager, who was present during the tour, stated the odor emanated from a resident room in which one of the two residents who resided there, was frequently incontinent. S/he further stated that the carpeting and a mattress had previously been replaced related to ongoing odor issues. A subsequent tour of the resident's room, at 5:00 PM, with the home's Administrator and Nurse Manager revealed ongoing strong urine odor within the residents' room.	R266		

Maple Lane Retirement Home
Plan of Correction
Survey 11/12/14

R134 Resident Assessments

The Assessments for Residents # 3 & 5 have been completed by our RN Manager. All other residents of the facility have the potential to be affected by this deficient practice. Accordingly we have audited all current resident assessments in order to verify that each resident has been assessed by our RN consistent with the required assessment schedule. To prevent this deficient practice from recurring we will make 2 adjustments. First, addition of RN hours will be provided to our Level III facility and secondly a formal tracking tool will be instituted relating to resident assessments.

The effectiveness of our corrective action will be monitored by our QA program. The facility Administrator will verify timelines of all resident assessments on a monthly basis utilizing the assessment tracking devise.

Claire Bishop, RN Manager will be responsible for the correction of the deficiency.

Completion Date 12/12/14

R145 Resident Plan of Care

Resident #3 plan of care had been reviewed and updated where indicated by our RN Manager to better address this resident's need relating to aggressive behavior and elopement concerns. All other residents of the facility have the potential to be affected by this deficient practice. Accordingly our RN Manger will review the Plans of Care of all other residents of the facility to ensure that their care plans assists each resident in maintaining independence and well being. To ensure that the deficient practice does not recur the RN Coordinators scheduled hours will be increased and reorganized to provide more consistent and timely RN participation in resident's plan of care. The effectiveness of our corrective action will be monitored by our QA program. The facility will conduct QA reviews on a sample of residents on a bi-weekly basis for 2 months. These reviews will be completed by our Administrator and RN Manager.

Claire Bishop, RN Manager will be responsible for the correction of this deficient practice.

Completion Date 12/12/14

R170 Staff Services Training

All staff members who failed top complete the required 12 hours of in-service training at the time of survey will complete the additional education hours needed to satisfy the requirements. Staff in-service hours will now be tracked and reported to Administrator on a monthly basis by the office manager. This adjustment will allow for more timely enforcement of facility policy related to mandatory training of staff and will ensure the deficient practice does not recur.
Frank Cheney, Administrator will be responsible for the correction of this deficiency.

Completion Date 12/12/14

R181 Staff Service Background Checks

The employee in question convictions have been reviewed by our Administrator and a variance request has been submitted to the Division of Licensing and Protection. We have reviewed the background checks of all other staff members in order to verify that additional employment action and/or variance requests where not needed. In order to ensure that the deficient practice does not recur our Abuse Prohibition policy and Procedures has been adjusted to reflect new facility practice of requesting variances for all employees found to have criminal convictions of any type.
Frank Cheney, Administrator is responsible for the correction of this deficient practice.

Completion Date 12/12/14

R189 Initial Assessments

The Assessments for Residents # 3 & 5 have been completed by our RN Manager. All other residents of the facility have the potential to be affected by this deficient practice. Accordingly we have audited all current resident assessments in order to verify that each resident has been assessed by our RN consistent with the required assessment schedule. To prevent this deficient practice from recurring we will make 2 adjustments. First, addition of RN hours will be provided to our Level III facility and secondly a formal tracking tool will be instituted relating to resident assessments.

The effectiveness of our corrective action will be monitored by our QA program. The facility Administrator will verify timelines of all resident assessments on a monthly basis utilizing the assessment tracking devise.
Claire Bishop, RN Manager will be responsible for the correction of the deficiency.

Completion Date 12/12/14

R248 Food and Sanitation

The grates of the hood vent were thoroughly cleansed and degreased. The metal sheeting has been reaffixed and sealed to prevent fire insulation from escaping this barrier. In addition we defrosted and cleaned the refrigerator, freezer and cooler found to be in unacceptable condition during our survey. In order to prevent the deficient practice from recurring we have added cleaning on a weekly basis of our Level III kitchen and equipment by our nursing facility dietary staff. This adjustment will supplement not replace our existing cleaning procedure presently completed by our level III Attendants. To ensure ongoing compliance our SNF Dietary Supervisor will inspect the level III kitchen on a weekly basis and report findings to facility Administrator.
Frank Cheney, Administrator will be responsible for the correction of this deficient practice.

Completion Date 12/12/14

R266 Physical Plant

1) The ceilings in the bathroom #3 & #7 have be repaired
2) The window located above the kitchen stove has been replaced
3) The resident room identified as emanating a strong odor has been emptied and thoroughly (spring cleaned) disinfected including carpets, curtains, walls, bedding, furniture and personal belongings. The resident in question plan of care has been reviewed and updated to include additional efforts to promote resident participation and cooperation with the plan of care relating to incontinent episodes. In addition this resident's room will be inspected on a weekly basis by the facility Administrative and Maintenance Director to determine if additional thorough cleaning is necessary and evaluate the effectiveness of the resident's plan of care in preventing the odor problem from recurring.
Frank Cheney, Administrator will be responsible for the correction of this deficiency.

Completion Date 12/20/14

Frank Cheney III Adm
12/17/14